

STATEMENT

By Arthur S. Flemming, Secretary of Health,
Education, and Welfare, August 26, 1959

The Federal Radiation Council

As most of you are probably aware, the President on August 14, 1959, issued an Executive order establishing the Federal Radiation Council, and along with the order the White House issued a press release which elaborated upon the order.

On August 22, the White House issued a second press release in which I had the honor of being designated by the President as the current chairman of the Federal Radiation Council. That press release also stated:

"The President also directed that the Department of Health, Education, and Welfare intensify its radiological health efforts and have primary responsibility within the executive branch for the collation, analysis, and interpretation of data on environmental radiation levels such as natural background, radiography, medical and industrial use of isotopes and X-rays, and fallout, so that the Secretary of Health, Education, and Welfare may advise the President and the general public."

The action of the President, as reflected in the three documents referred to above, constitutes, in my opinion, a constructive and effective method for dealing with the growing problems of radiological health protection.

Under the President's directive, the existing work of this Department in the radiological health field will be intensified, and the Department will undertake the additional "primary responsibility within the executive branch for the collation, analysis, and interpretation of data on environmental radiation levels . . ."

As a first step in organizing the Department for our expanding work, I have made specific delegations of responsibilities for radiological health activities. These responsibilities, which primarily concern the Public Health Service and the Food and Drug Administration, are

spelled out in the "Manual of General Program Policy—Part 10, Radiation Health," dated August 1959. This is being made a part of the Department's internal manual in which general program policy is set forth.

It should be noted that I have assigned to the Public Health Service the responsibility for "collation, analysis, and interpretation of data on environmental radiation levels as a basis for the Secretary's advice to the President and the general public."

Financial ability, of course, is always an important factor in undertaking new work. For the current fiscal year we have funds available as shown below. For comparison I have also listed the funds that were available in the preceding fiscal year.

	<i>Fiscal year</i> 1959 (<i>actual</i>)	<i>Fiscal year</i> 1960 (<i>available</i>)
Food and Drug Administration-----	\$78, 500	\$400, 000
Public Health Service:		
Division of Radiological Health-----	634, 100	2, 489, 100
General research and services-----	289, 000	300, 000
Cancer research ¹ -----	15, 000	15, 000
Total -----	\$1, 016, 600	\$3, 204, 100

¹ Represents costs of a special study of the effects of uranium radiation on uranium miners.

It will be noted that the 1960 funds are a substantial increase over the funds for 1959.

In addition to the funds identified in the table, the National Institutes of Health also expend funds for therapeutic and diagnostic services in the radiological field. For 1960, the funds available for this purpose total \$3,000,000.

In allocating the funds for 1960, careful consideration will be given to the new assignments given to the Department by the President. As

soon as I know how far we can go in carrying out the President's assignments with available funds, I will give consideration to the question of requesting additional funds. It is not necessary for me to cross this bridge at the present time, because such a request cannot be adequately developed and considered until the Congress reconvenes in January.

The Department approaches its expanding role in the radiological health field with the most serious determination to carry out the President's assignment. At the same time, we are sensitive to the complexities involved in the subject, and we have the utmost respect for the labors of the pioneers, both in and out of government, who have preceded us.

Summary of a Doctoral Dissertation

LONGITUDINAL STUDIES OF TUBERCULOSIS PATIENTS REGISTERED IN HAWAII: FACTORS IN SURVIVAL RATES

Survival patterns of tuberculosis patients were investigated. The material was supplied by the history of 4,909 persons placed on the Hawaii tuberculosis case register during the period of January 1, 1947 to June 30, 1953. Various patient-cohorts were categorized by medical and demographic characteristics on registration and by mode of detection of the patient. Survival rates were computed for successive periods after registration for each cohort by methods of analysis which eliminate all competing causes of removal from the register other than death from tuberculosis. The "net" survival rate, so obtained, was used for the comparison of risks of death from tuberculosis in different patient-cohorts.

Of the total study population, 91 percent were alive 6½ years after registration. Patients whose disease was "active" on registration showed a much lower survival rate than did the "nonactive" patients. The rate of mortality from tuberculosis diminished with time after registration, particularly for the "active" patient. The significance of "activity undetermined" seemed dubious from the survival pattern. A clear time trend was noticed for

survivorship improving with year of registration, especially in "active" patients.

The survivorship differed by certain medical and demographic factors. In general, the variation was relatively large in "active" patients but it was relatively slight in "nonactive" patients. The survival rate varied more strongly by bacteriological finding than by clinical sign of activity status of the disease. The mortality was greatest for far advanced active patients.

Survivorship was relatively low for the first five years of life, rose to a maximum at the 15-24 age group, and then decreased with age. Little difference in survival by sex was noticed within specific age groups. The mortality peak observable with the group of adolescents and young adults in the general population, especially in the developing countries, may be due to excessive exposure rather than lowered resistance. Survivorship varied considerably by race.

Patients detected by minifilm surveys had more favorable survival rates than those first diagnosed because of "symptoms."—CHAI BIN PARK, M.D., M.P.H., PH.D., *University of California, 1959.*